SUSPICIOUS HEALTH CLAIM/APPLICATION NOTIFICATION FORM
OIFP-4 (01/01)

For OIFP use only:

OIFP Case # ____/_____/____

Intake # _____

Investigator _____

State of New Jersey
Office of Insurance Fraud Prosecutor
P.O. Box 094
Trenton, NJ 08625

PART I

INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE _____

CONTACT PERSON _____

E-MAIL ADDRESS _____

NAIC # _____

D.O.L. _____

CLAIM # _____

POLICY # _____

TYPE OF COVERAGE (Check appropriate box)
HEALTH (INDEMNITY) ☐ HEALTH (MEDICAID) ☐
HEALTH (HMO) ☐ DENTAL ☐
OTHER _____

STATUS (Check appropriate box)
PENDING ☐ PAID - IN FULL ☐
DENIED ☐ PAID - IN PART ☐
OTHER ☐
AMOUNT PD $_____ DATE/RANGE PD_____
IF PENDING OR DENIED, EITHER IN FULL OR IN PART, THE DOLLAR AMOUNT OF THE PENDING OR DENIED CLAIM: $_____

INSURED/SUBJECT/PROVIDER (CIRCLE)

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE-ZIP _____

HOME PH. _____ WORK PH. _____ D.O.B. _____

S.S./T.I.N # _____ D.L. # _____

LICENSE # _____ STATE _____

BUSINESS NAME _____ TIN # _____

IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. 17:33A-4?
YES ☐ NO ☐
IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

_____
_____
_____
_____
_____
_____

PART II

PROVISIONS OF N.J.S.A. 17:33A-4 RELATING TO FALSE CLAIMS THAT MAY HAVE BEEN VIOLATED:
(CHECK APPROPRIATE BOX OR BOXES)

☐ **a(1) - presents false information**: KNOWINGLY PRESENTS OR CAUSES TO BE PRESENTED AN WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE MISLEADING INFORMATION CONCERNIN ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(1)

☐ **a(2) - makes a false statement:** KNOWINGLY PREPARES OR MAKES ANY WRITTEN OR ORA STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT O THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(2)

☐ **a(3) - conceals relevant information:** CONCEALS OR KNOWINGLY FAILS TO DISCLOSE TH OCCURRENCE OF AN EVENT WHICH AFFECTS ANY PERSON'S INITIAL OR CONTINUED RIGHT O ENTITLEMENT TO PAYMENT OF A CLAIM. N.J.S.A. 17:33A-4A(3)

☐ **b - conspires with another:** ASSISTS, CONSPIRES WITH OR URGES ANY PERSON OR PRACTITIONE TO VIOLATE ANY PROVISION(S) OF THIS ACT. N.J.S.A. 17:33A-4B. (IF SO, SPECIFY WHICH PROVISION(S) THE ACT WERE VIOLATED _____).

☐ **c - knowingly benefits from insurance fraud:** DUE TO THE ASSISTANCE, CONSPIRACY OR URGIN(OF ANOTHER, KNOWINGLY BENEFITS, DIRECTLY OR INDIRECTLY, FROM THE PROCEEDS DERIVEI FROM A VIOLATION OF THIS ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WE VIOLATED _____).

☐ **d - involvement of hospital:** AN OWNER, ADMINISTRATOR OR EMPLOYEE OF ANY HOSPITAL WH(KNOWINGLY ALLOWS THE USE OF THE FACILITIES OF THE HOSPITAL BY ANY PERSON I FURTHERANCE OF A SCHEME OR CONSPIRACY TO VIOLATE ANY OF THE PROVISION(S) OF THE ACT N.J.S.A 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED _____).

☐ **e - using or being a runner:** A PERSON OR PRACTITIONER FOR PECUNIARY GAIN, DIRECTLY O INDIRECTLY SOLICITS:

- ☐ ANY PERSON OR PRACTITIONER TO ENGAGE, EMPLOY OR RETAIN A PERSON TO MANAGE ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.
- ☐ ANY PERSON TO BRING CAUSES OF ACTION TO RECOVER DAMAGES FOR PERSONAI INJURIES/DEATH.
- ☐ ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A 4E.

☐ **a(4)(b) - makes a false statement (application):** PREPARES OR MAKES ANY WRITTEN OR ORAI STATEMENT, INTENDED TO BE PRESENTED TO ANY INSURANCE COMPANY OR PRODUCER FOR THI PURPOSE OF OBTAINING AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO AN INSURANCE APPLICATION OR CONTRACT. N.J.S.A. 17:33A-4A(4)(B)

☐ **a(5) - conceals relevant evidence of application fraud:** CONCEALS OR KNOWINGLY FAILS TC DISCLOSE ANY EVIDENCE, WHICH MAY BE RELEVANT TO A FINDING THAT A VIOLATION OF N.J.S.A 17:33A-4A(4) HAS OCCURRED. N.J.S.A. 17:33A-4A(5).

PART III

1. INDICATE THE PARTICULAR FACTS AND CIRCUMSTANCES, INCLUDING WHAT TH APPLICANT/CLAIMANT DID AND FRAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WA VIOLATED, AS CHECKED ABOVE:

(MERELY STATING "SEE ATTACHED" FILE OR DOCUMENT IS NOT ACCEPTABLE WITHOUT SPECIFIC DESIGNATI OF PAGE AND LINE REFERENCED, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)*

2. INDICATE ALL STATEMENTS MADE WHICH YOU SUSPECT TO BE FALSE AND IDENTIFY ANY RELEVAN INFORMATION OMITTED. IDENTIFY ANY DOCUMENTS WHICH INCLUDE THE FALSE INFORMATION OI WHICH OMITTED RELEVANT INFORMATION:*

3. INDICATE ANY FACTS AND CIRCUMSTANCES WHICH PROVIDE ANY BASIS TO SUSPECT THAT A LICENSED PROFESSIONAL MAY HAVE KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS EMPLOYER:*

NOTE: IF THE INSURANCE COMPANY PAID MONEY FOR A CLAIM(S), OBTAIN ALL CLAIMS CHECKS AND SUBMIT TO OIFP AS SOON AS PRACTICABLE AFTER SUBMISSION OF THIS NOTIFICATION FORM.

*** For each document listed in support of the allegation of fraud, please attach an exact copy o the original. In addition, as to all documents attached to this form, please complete the attache Certification of Custodian of Records.**

CERTIFICATION OF CUSTODIAN OF RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person wi actual knowledge in the regular course of business at the time the activity took place. If additional records later becor known or available, I shall promptly provide them to the Office of Insurance Fraud Prosecutor. I certify that t foregoing statements by me are true. I am aware that if any of the foregoing statements made by me are willfully fal I am subject to punishment.

(List each document in this space or reference a separate attached listing)

_____

Custodian of Records
(Full Name and Title)

Dated:

PART IV *COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS OF THE INVESTIGATION*

INFORMATION REGARDING ANY ADDITIONAL INSUREDS:

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE/ZIP _____

HOME PH. _____ WORK PH. _____ S.S. # _____

D.L. # _____

CLAIMANT #1 (IF OTHER THAN INSURED/SUBJECT)

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE/ZIP _____

HOME PH. _____ WORK PH. _____ S.S. # _____

D.L. # _____

CLAIMANT #2

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE/ZIP _____

HOME PH. _____ WORK PH. _____ S.S. # _____

D.L. # _____

CLAIMANT #3

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE/ZIP _____

HOME PH. _____ WORK PH. _____ S.S. # _____

D.L. # _____

PART V *COMPLETE THE FOLLOWING ONLY IF LICENSED PROFESSIONALS ARE SUBJECTS OF THE INVESTIGATION*

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER ____________________ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST ____________________ FIRST ____________________ MIDDLE __________ LIC # __________

EMPLOYER ____ PHONE # ____________________

ADDRESS ____ TAX ID # ____________________

ADDRESS (CONT.) ______________________________ D.O.B. ______________ S.S. # ______________

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER ____________________ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST ____________________ FIRST ____________________ MIDDLE __________ LIC # __________

EMPLOYER ____ PHONE # ____________________

ADDRESS ____ TAX ID # ____________________

ADDRESS (CONT.) ______________________________ D.O.B. ______________ S.S. # ______________

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER ____________________ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST ____________________ FIRST ____________________ MIDDLE __________ LIC # __________

EMPLOYER ____ PHONE # ____________________

ADDRESS ____ TAX ID # ____________________

ADDRESS (CONT.) ______________________________ D.O.B. ______________ S.S. # ______________

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER ____________________ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST ____________________ FIRST ____________________ MIDDLE __________ LIC # __________

EMPLOYER ____ PHONE # ____________________

ADDRESS ____ TAX ID # ____________________

ADDRESS (CONT.) ______________________________ D.O.B. ______________ S.S. # ______________